Thank you for the opportunity to testify before the committee. I want to thank you for the support the State provides to higher education; higher education is the engine that can and will transform the Michigan economy by training a work force to attract new high quality jobs and residents to our great state.

First, I would like to clarify that I do not come here representing the University of Michigan who is my employer, but rather as Chair of the Committee on the Economic Status of the Faculty, which is a faculty governance committee based on elected representation of the faculty of the University of Michigan. We embrace providing high quality benefits in the most cost effective structure. The University, with the support of its faculty, has been a leader and innovator in continuously reforming its employee health care programs. The University of Michigan has been looked to as a model for their employee health benefit management by other Universities across the nation.

I am told that the official position of the University of Michigan on this bill is neutral, although the University does not anticipate participating if passed as we anticipate being more cost effective. I come here, based on elected faculty representation, as Chair of the Committee on the Economic Status of the Faculty appointed by SACUA and confirmed by the faculty's Senate Assembly, to be certain you know that our faculty committee does not wish their benefits to be managed as proposed in this bill without further revision.

We have a lengthy history of health care reform in Ann Arbor, as cost containment is a dynamic process and not a hinge point in time. Drawing on expertise including faculty in diverse areas such as the College of Pharmacy, The Center for Value Based Insurance Design, and The Center for Healthcare Research and Transformation, the University has successfully controlled the rate of increase in its healthcare costs and is a model for health care

management that is being emulated across the country. Local control has allowed for substantial innovation.

Working on health care as a local issue has promoted investments in initiatives such as the Michigan Healthy Living Initiative and implementation of a Data Warehouse initiative which allows the University to track the success of interventions and cost effectiveness of health care on outcomes. Local management of our Pharmacy benefit has resulted in a marked shift to generic medications while using SXC as a claims processor. We have used our faculty expertise to design prescription drug benefits which are leaders in cost containment and high quality care.

We have high quality benefits with a lower cost structure as a result. This benefit design has withstood the test of competition, being lower than the MUCH university consortium of healthcare, as well as lower than a BCN pooled pharmacy benefit. I want to point out that when we looked at the option of transitioning to a BCN pooled pharmacy benefit, we would have lost local control and innovation going forward, as well as had tremendous expense and discomfort adopting their structured therapies with different formulary step therapies. The University did not perceive a cost benefit to what competitors offered.

Following my brief introduction, I would now like to direct my attention to specific concerns with the bill. How can we maximize purchase pooling power when essentially only one insurer provides coverage across the whole state? It is almost as if this bill is crafted for a single insurance provider, as there appears to be an insurer that can provide health insurance coverage throughout the state at this time. The bill seems like a slam dunk win for Blue Cross Blue Shield. In the long run, a single insurer will likely be able to set their price unless the State breaks up the very pool it is trying to create into local or regional pools in order to generate more competitive bidding.

One mechanism by which purchasing power can be pooled is to carve out the pharmacy benefit portion of the State employee's healthcare to increase pill purchasing power. We propose that the state could study this further through CHRT, the Center for Health Research and Transformation at the University of Michigan. While this approach is fraught with challenges including transitioning from different stepped formularies and blending multiple health delivery systems, it could warrant further study. One can even wonder if the University of Michigan model for pharmacy benefits could be adopted across the State.

Another concern with the proposed State health care reform is its timing during a period of ongoing National health reform. We propose the State consider a health reform study looking at the impact of new tools which may become available such as health insurance exchanges. Again, CHRT could perform a health reform study to look at how other states are managing their health care and what factors are unique to the Michigan market.

We also have been able to invest locally in preventive health measures such as a Michigan Healthy Living initiative to increase fitness and cut long term health costs. Local investments in disease prevention will be discouraged if savings are not realized locally but rather globally. Why would an employer spend on prevention if they did not realize the savings from their investment?

Concerns will the bill
Sec 2(e) - Will universities be required to enroll? Doesn't this violate the independence clause of the constitution?

Sec 3(2a) - Having 4 committee members represent diverse employees cannot possibly adequately represent the various

concerns and interest of dozens of unions and thousands of non-unionized employees.

Sec 12 (b) - Wellness programs are obviously a good idea but where will the state find the resources to front the initial costs of these programs and who will monitor their progress/effectiveness? Today employers have a financial reason to encourage healthy lifestyles, but this bill removes that incentive.

Secs12-14 - The new state employer agency will be tasked with creation of this program; formulation of plans; monitoring the cost containment of those plans; implementing the program's incentives; and creating/implementing/evaluating the numerous cost saving measures. This charge seems to be a very tall task, especially considering self-insured employers have been trying this for years with limited success - and likely a much larger compensation budget.

Sec 19 - Opt-out. We are aware that other individuals have expressed concern over the cost of opt-out before this committee. The bill lists a 5% savings minimum to opt-out. What if the committee decided (it is the committee's decision) that a group of employees (say the U-M faculty and staff) were too valuable to the purchasing power of the committee regardless of their benefits cost? Is it ok if they are at 6% lower, 8% 10%? To whom can an employer appeal to remain independent? We propose an OPT-IN structure rather than an OPT-OUT structure. If the state can provide a high quality benefit at a lower cost structure, let employees OPT-IN to the health insurance plan during open enrollment. One of the key tenants of any health care reform should be to preserve CHOICE.

Alternatives

Pharmaceutical plan (OPT-IN). The state's Medicaid multi-state pooling plan is an example of how this can save money. Perhaps the increased purchasing power of the public employees (especially the retirees) might further increase savings.

Another option would be for the state to create a plan to compete with private insurers. Public employees and unions have the option of selecting this or any other available plan. Such a program could also be open to individuals and small businesses.

The speaker anticipates $700-$900 million dollars in savings. What will this state do if after creating the bureaucracy to run this program and our school districts and local governments downscale their benefits staff, those savings don't materialize? How long does this experiment continue and how do we go back?

While obviously lower premiums are better, the biggest concern is the escalation of health care costs and providing high quality benefits in the most effective cost structure.
Michigan's health care spending will likely be in the realm of $60-$70 billion dollars this year (using 2004 kaiser data and 5% growth). If the state merely dictates to health providers a cut in revenue from state employees by $900 million, and we are not saying it can, won't this cut be an effective tax on everyone else who pays for health insurance in the State? The savings need to be real reductions in cost, not merely cuts in reimbursement. Insurance companies and hospitals will not are be able to absorb a drop in revenue and continue to provide for the uninsured and underinsured. In short, a forced cut in reimbursement will lead to a rise in everyone else's premiums to cover this "taxpayer savings." This is really like passing a new tax on everyone else in the state. We believe the emphasis should be on value based medicine, rather than just on cutting reimbursement.

Precisely how would opting out work? Who would account for costs? What about costs of conversion? Health insurance is not like leasing a car where you turn the old one in and drive off in the new one. Transitioning stepped pharmacy benefits, provider networks, and plan coverage has huge administrative and over head costs as well as time and anxiety costs for the covered employees. Would Universities have to opt out annually? Would they be protected from political coercion to participate? How would they be protected from a health insurer providing a "low ball" bid to get everyone covered and then jacking rates up in subsequent years, with the costs of back conversion being prohibitive? The option to opt out needs to be a real option, not just another Michigan Promise.

Finally, we do not believe that the bill is constitutional. The University of Michigan has never been part of state employee benefits or compensation. Neither have any of the other state Universities. How Universities allocate finances to pay for things, things such as salaries and benefits, are expressly autonomous under the constitution of the State of Michigan. The bill as it stands explicitly naming and including the University of Michigan is almost certainly unconstitutional. We respectfully ask that direct mention of the University of Michigan be deleted from the bill, and that the mechanism of opt out be at the discretion of the University, which would allow the State option to compete for the University's health care business on the basis of price and quality at the University's discretion to participate. The University competes globally, and we believe it needs to provide competitive benefits for its unique marketplace. We believe the University is currently providing high quality benefits at a lower cost structure than currently available alternatives. This high quality low cost structure is possible through local control over our benefit plans with the University managing its own pharmacy benefit, prevention, and disease management programs. We applaud the

State's efforts to reduce health care costs and provide high quality benefits in an effective lower cost structure.